Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
101 PASEO DEL PRADO
EDINBURG TX 78539

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
01

MFDR Tracking Number
M4-10-4191-01

MFDR Date Received
MAY 27, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The Request For Reconsideration Letter Dated April 7, 2010 : "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on DRG 460, allowed amount is $30,821.71 multiplied at 108 percent, the account reimbursement, which includes $13,114.60 for implants, should be $46,402.05. Payment received was only $37,363.26, thus, according to these calculations; there is a pending payment in the amount of $9038.79."

Amount in Dispute: $9,038.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We based our payments on the Texas Fee Guidelines and the Texas Department of Insurance/Division of Workers' Compensation Commission's Acts and Rules…The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows: The provider was appropriately reimbursed at 108% of the Medicare rate for DRG 460. The provider did not submit **certified invoices on initial review or with appeal**. Rule 134.404(g)(1). This rule is for providers asking for separate reimbursement for implants. The provider must certify each invoice with the statement, 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.' Liberty Mutual believes that Doctors Hospital at Renaissance has been appropriately reimbursed…"

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Road, Gainesville GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2010 through January 20, 2010	Inpatient Hospital Surgical Services	$9,038.79	$6,711.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 1, 2010
   - Z547 — 45 — THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - 42 — Z710 — THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - 42 — PA— FIRST HEALTH
   - 24 — (P303) — THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)

   Explanation of benefits dated April 16, 2010
   - Z547 — 45 — THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - 42 — Z710 — THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - 42 — PA— FIRST HEALTH
   - 24 — (P303) — THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
   - B406 — DOCUMENTATION NOT SUBMITTED OR INSUFFICIENT TO ACCURATELY REVIEW THIS BILL. (B406)
   - X598 — CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason code "Z547 — 45 — THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 22, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the

Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
(A) 143 percent; unless
(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

The requestor states in their request for reconsideration "Based on DRG 460, allowed amount is $30,821.71 multiplied at 108 percent, the account reimbursement, which includes $13,114.60 for inplants, should be $46,402.05." Although the requestor asked for separate reimbursement for implantables, review of the documentation finds that the requestor did not include a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable in accordance with Texas Administrative Code §134.404(g)(1). Specifically the requestor did not include the sentence "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." As the requestor did not bill in accordance with subsection (g) of §134.404, the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 460, and that the services were provided at Doctor's Hospital at Renaissance. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $30,821.71. This amount multiplied by 143% results in a MAR of $44,075.05.
4. The division concludes that the total allowable reimbursement for the services in dispute is $44,075.05. The respondent issued payment in the amount of $37,363.26. Based upon the documentation submitted, additional reimbursement in the amount of $6,711.79 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,711.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 7, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a**

copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.